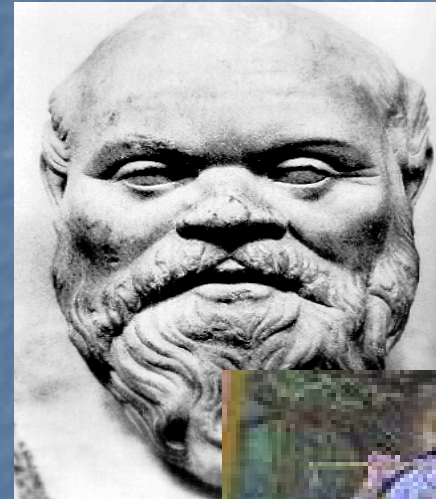


# Ethics at Harvard Medical School

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# What do we mean by “ethics”?

- Ethics as an agenda or as analysis?
  - Meta
    - Sources
  - Normative
    - Standards
  - Applied
    - Specific controversies
      - Clinical medical ethics
      - Research ethics



# Our initial pedagogical questions

- What is the purpose of an ethics education in medical school?
  - Dispelling the is-ought fallacy?
  - Who is best suited to teach bioethics to medical students?
- How can we measure the “effectiveness” of bioethics education after medical school?
  - Where “is” overwhelms “ought”

# Can “ethics” be taught to medical students?

- Character/Internal Compass
  - Largely a product of nurturing/socialization/?genetics
- Moral reasoning
  - Understand and identify what values are at stake
  - Understand conceptual dichotomies
    - Consequentialist vs. Deontological concerns
  - Identify best course of action in light of available moral considerations, available evidence
    - Bringing discipline and order to the emotional, intuitive, socio-cultural influences

# American Medical School Experience

- AAMC requires all medical schools to have curriculum in ethics
- Few descriptive studies on curricula
  - ~80% integrate ethics into larger coursework
  - No uniformity across schools on content, number of hours, or method of teaching
  - Commonly identified barriers to education:
    - Lack of dedicated time in curriculum
    - Lack of qualified teachers
    - Lack of time in faculty schedules

# American Medical School Experience

- Goals of Ethics education
  - 2 viewpoints predominate in US
    - Create “virtuous” physicians
    - Providing skills for ethical analysis and decision-making
      - Neither can be accomplished with current curricular efforts
        - Limited data suggests little impact over course of undergraduate education on improving either virtue or reasoning skills

# Bioethics at Harvard Medical School

- 1<sup>st</sup> year
  - Mandatory semester course: "Medical Ethics and Professionalism"
    - Taught by mix of core philosophers and clinicians
  - Doctor-patient course
- 2<sup>nd</sup> year
  - Doctor-patient course
  - Ethics Journal Club
- Clinical years – ad hoc encounters
- Beecher Prize
- Access to numerous educational activities of DME

# 1<sup>st</sup> year mandatory course

- Provides an overview of many ethical issues that arise in the practice of medicine and research
- Focused on core aspects of ethical reasoning
  - *Professionalism* topics: Truth telling, Informed Consent, Confidentiality, Professional Boundaries, Conflicts of Interest, Surrogate Decision-making
  - *Specific clinical* topics: Genetic testing, Macro and Micro-rationing, Research ethics, Physician-assisted suicide, Euthanasia, Reproductive medicine, Personal responsibility for health

# 1<sup>st</sup> year class format

- Discussion groups of 12-15 students
- 2 hours/week for 14-16 weeks
- 2-3 Plenary sessions
- Minimal didactics – encourage interactive discussion with facilitation by instructor
- 500 word essay on readings/cases each week
- Option of final exam or longer paper

# Case Example: COI

- You are now Chief Resident at a prestigious Harvard teaching hospital. A major drug company has invited you to a meeting on the treatment of a major condition in your specialty area that will be held at a Caribbean resort. The company has a new product for the treatment of this condition, which will be discussed along with alternative treatments. They will pay all of your and your spouse's expenses for the day of the meeting and an additional day at the resort, plus a \$1000 honorarium for attending the meeting . What should you do?

# Example: Informed Consent and Truth-telling

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ANNALS OF MEDICINE

## THE LEARNING CURVE

*Like everyone else, surgeons need practice. That's where you come in.*

BY ATUL GAWANDE

GAWANDE

The patient needed a central line. "Here's your chance," S., the chief resident, said. I had never done one before. "Get set up and then page me when you're ready to start."

It was my fourth week in surgical training. The pockets of my short white coat bulged with patient printouts, laminated cards with instructions for doing CPR and reading EKGs and using the dictation system, two surgical handbooks, a stethoscope, wound-dressing supplies, meal tickets, a penlight, scissors, and about a dollar in loose change. As I headed up the stairs to the patient's floor, I rattled.

I said nothing of such things, naturally, when I asked the patient's permission to do his line. He said, "O.K."

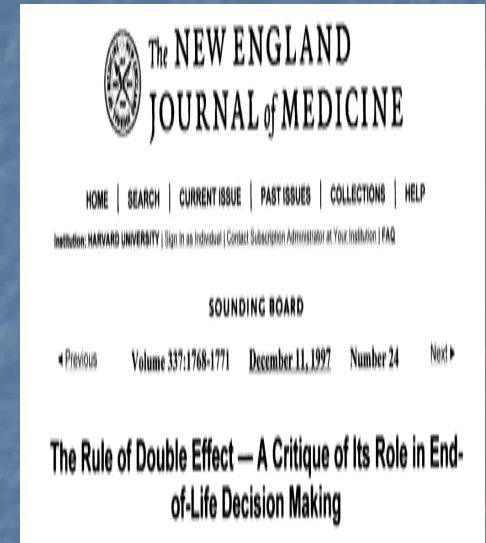
I had seen S. do two central lines; one was the day before, and I'd attended to every step. I watched how she set out her instruments and laid her patient down and put a rolled towel between his shoulder blades to make his chest arch out. I watched how she swabbed his chest with antiseptic, injected lidocaine, which is a local anesthetic, and then, in full sterile garb, punctured his chest near his clavicle with a fat three-inch needle on a syringe. The patient hadn't even flinched. She told me how to avoid hitting the

right place," she said to me quietly. Then to the patient: "You're doing great. Only a few minutes now." She pulled the needle out over the wire and replaced it with a bullet of thick, stiff plastic, which she pushed in tight to widen the vein opening. She then removed this dilator and threaded the central line—a spaghetti-thick, flexible yellow plastic tube—over the wire until it was all the way in. Now she could remove the wire. She flushed the line with a heparin solution and sutured it to the patient's chest. And that was it.

Today, it was my turn to try. First, I had to gather supplies—a central-line

# Example: End of life issues

- A patient comes in alone by ambulance to ER unconscious and not breathing. He is intubated and placed on LSMT. His prognosis is favorable for recovery from the acute episode. His family comes in later and shows you an advanced directive stating the patient never wanted to be intubated because he has numerous co-morbidities that compromise his quality-of-life. What should you do?



# We have modest goals

- Introduce issues of both practical and intellectual importance to future physicians
  - Laying a foundation
  - “Philosophy light” – Evaluating moral justifications
  - Liberate rather than inculcate
- Less about providing clear answers (and problem-solving)
  - But emphasize that some issues seem settled

# We have modest goals

- More about asking:
  - good questions (noticing a problem)
  - developing critical reasoning skills
  - fostering an ability to think critically and independently regardless of the normative practice witnessed
- Encourage interest early that can be further stimulated as education/apprenticeship proceeds
  - Honors thesis opportunities for 4<sup>th</sup> years
  - Filling critical gaps in clinical years/internship/house officership

# We have modest goals

- Recognize that ethics education is neither perfect nor a panacea
  - Cannot *by itself* transform professional attitudes/conduct/normative behavior
  - This mode of learning is difficult for many
  - Highlighting tensions (value trade-offs) can be frustrating for students

# An optimistic note from US experience

- Behind every question in medical ethics is a question of individual rights and social regulation...
  - What are the normative consequences of an evolving or evolved professional practice in an area where moral controversy exists?
    - Duty to encourage students to be self-aware, reflective, and critical of suspect traditions/practices can lead to incremental change



# Alternatively, “an immodest proposal”

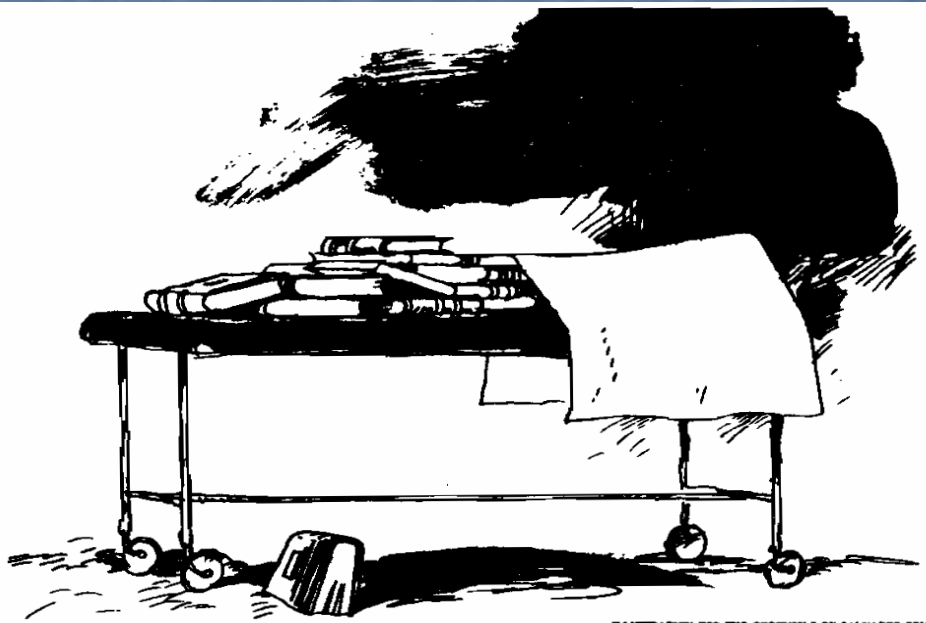


ILLUSTRATION FOR THE CHRONICLE BY SALVADORE DDU

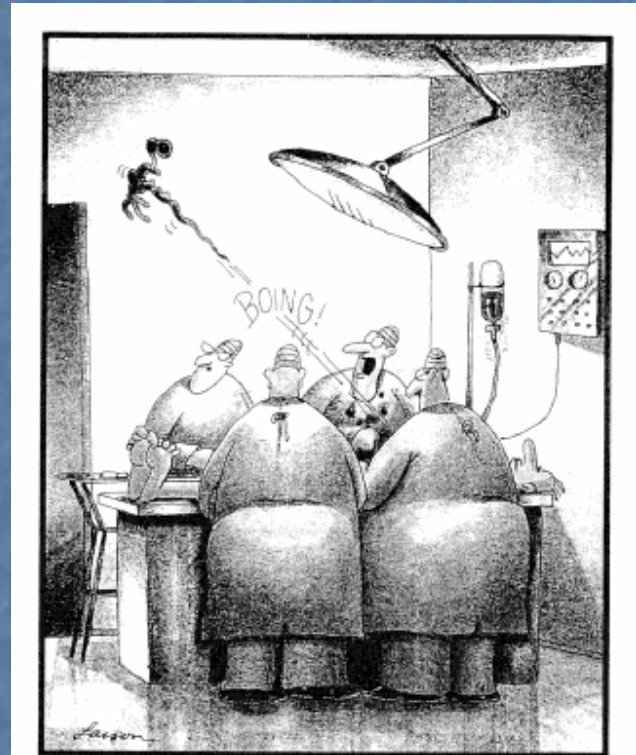
## *The Pre-Med Syndrome*

Abolishing the special curriculum for future physicians could be a boon to undergraduate liberal-arts education



# Some concluding reflections

- My congratulations
- A gentle reminder:  
Pedagogy vs. Activism
  - Contextual Ethics:
    - prioritizing the worry about justice and equity in India
  - Moral Absolutism
    - closing discussion is antithetical to the enterprise of ethics education



*"Whoa! Watch where that thing lands -  
We'll probably need it."*

# Thank you

